Financial Institution Data Matching Program Agreement

Rev. 1/05

STATE OF UTAH
DEPARTMENT OF HUMAN SERVICES
Office of Recovery Services/Child Support Services

PURPOSE:

This agreement is between the Utah State Department of Human Services, *Office of Recovery Services/Child Support Services,* herein after referred to as *ORS,* and, _____ _____ _____, herein after referred to as the *Financial Institution.* This Agreement establishes requirements to be met by the *ORS* and *the Financial Institutio*n, pursuant to Utah Code Annotated 62A-11-304.5 and section 466(a)(17) of the Social Security Act, for the purpose of developing and operating a data match system. The *Financial Institution* shall participate in the automated exchange of data by providing, on a quarterly basis, identifying information for each non-custodial parent who maintains an account at such institution and who owes past-due support, as identified by the *ORS*. The automated data exchange system will be implemented and managed through the child support enforcement program of the *ORS* and/or its authorized agent.

Financial Institution agrees to the following:

1. Submit the required data quarterly using one of the approved methods.
2. Submit for reimbursement based on incurred cost using the FM01 reimbursement request.
3. Contact the ORS Financial Institution Data Matching Program Coordinator with any questions or concerns.
4. Protect the confidentiality of any data/information supplied to the financial institution by ORS.

Office of Recovery Services/Child Support Services agrees to the following*:*

1. Maintain an FTP site and provide alternate options for receiving/submitting data to financial institutions.
2. Accept and process data received within 30 days.
3. Reimburse Financial Institution based on quarterly incurred cost.

4. Provide information as needed.

ACTION:

To participate, the *Financial Institution* must sign and return this Agreement by February 1, 2005.

PARTIES TO THE AGREEMENT:

Tiffeni Wall	
Project Coordinator	**Contact Name**
Office of Recovery Services	
Agency	**Institution Name**
PO Box 45033	
Address	**Address**
Salt Lake City, UT 84145-0033	
City State Zip	**City State Zip**
orsfidm@utah.gov	
E-mail Address	**E-mail Address**
(801) 536-8902 (801) 536-8509	
Phone Fax	**Phone Fax**

DATA ELEMENTS AND REQUIREMENTS:

All data supplied under this Agreement as required below shall be in accordance with the Financial Data Match Specifications Handbook. (Published/Distributed – August 2001).

TRANSMITTING METHODS:
The following are the accepted transfer media used by the *ORS* at this time. Please check the type of media selected:

- ☐ FTP
- ☐ 3480 CARTRIDGES
- ☐ 3490 CARTRIDGES
- ☐ MANUAL MATCH (600 accounts or less)
- ☐ METHOD 1
- ☐ METHOD 2

Those institutions electing to receive a 3490E cartridge will be required to return the data on a 3490E cartridge. Institutions are advised that the *ORS* will return all used tapes/cartridges to the initiating *Financial Institution.* The *ORS* will require the return of

the *ORS* tapes/cartridges after the completion of each quarterly match. Retention of the used tapes/cartridges will result in a fee charged to the *Financial Institution.*

AGENT:

The *Financial Institution* may designate an agent to perform the data match on its behalf by completing the information below.

Agent: _____

Contact Person: _____

Title: _____

Street Address: _____

Mailing Address (if different)_____ Telephone_____

Fax: _____ E-mail: _____

COSTS AND FEES:

In accordance with Utah Code Annotated 62A-11-304.5, the *ORS* may pay a reasonable fee to a *Financial Institution* for compliance with this program. The reimbursement may not exceed the actual costs of the transference and matching of data. The reimbursement does not include programming costs and will not exceed $150.00 per quarter.

If a *Financial Institution* seeks a quarterly reimbursement, the *Financial Institution* shall be required to furnish the *ORS* an account of expenditures/costs incurred in the performance of transfer services. The *Financial Institution* shall submit an itemized statement of services rendered for the prior quarter and an ORS FM01 FORM, (*Financial Institution Reimbursement Request)* within 30 days of the end of each calendar quarter. Claims shall be submitted to:

Attention: Tiffeni Wall
Office of Recovery Services
PO Box 45033
Salt Lake City, UT 84145-0033

(801) 536-8902 Fax: (801) 536-8509 E-mail: orsfidm@utah.gov

ADDITIONAL TERMS:

This agreement will commence February 1, 2005 and end February 1, 2008. The Agreement may be amended, waived or voided in writing at any time by mutual consent of both parties.

SIGNATURES:

Financial Institution:

Financial Institution Name

Contact Signature **Title** **Date**

Financial Institution Service Provider (If Applicable):

Institution Name

Agent Signature Title Date

Office of Recovery Services/Child Support Services:

Emma L. Chacon Director, ORS Date

James N. Kidder IV-D Director, Deputy Director, ORS Date

Mike Tazelaar Deputy Director, ORS Date

Tiffeni Wall Financial Institution Matching Coordinator Date

Office of Recovery Services
FIDM QUARTERLY TRANSMITTAL FORM

INSTITUTIONS WITH 600 OR FEWER ACCOUNTS
FM02
Rev. 1/05

Date Reported: _____ TIN#: _____

Institution Name: _____

Address: _____

Contact Person: _____

Phone: _____ Fax:_____ E-mail:_____

Number of Accounts Reported: _____ Hard Copy Attached: _____

Comments:
_____
_____
_____
_____

Please return this form with each Quarterly Manual Match to:

Attention: Tiffeni Wall
Office of Recovery Services
PO BOX 45033
Salt Lake City, UT 84145-033
(801) 536-8902
Fax: (801) 536-8509
E-mail: orsfidm@utah.gov

Financial Institution Reimbursement Request

Rev 08/04

State of Utah

Department of Human Services
Office of Recovery Services
FM01

Reimbursement request date: _____
***NOTE: Reimbursement requests must be submitted within 30 days of the end of the quarter. Reimbursements received after this period will not be paid.**
Quarter in which cost was incurred: (check one)
1st Quarter: _____ 2nd Quarter: _____ 3rd Quarter: _____ 4th Quarter: _____
(Jan, Feb, Mar) (Apr, May, June) (July, Aug, Sept) (Oct, Nov, Dec)

Institution Name ***TIN/EIN***

_____
_____***Address*** ***Telephone***

_____
_____
Contact Name ***Telephone***

_____
_____
Service Agent Name ***TIN/EIN***

_____
_____ ***Address*** ***Telephone***

_____
_____
Contact Name ***Telephone***

_____
Service Agent's Signature: (person authorized to request reimbursement match) **Date:**

_____

Actual Cost of Match: $

*** NOTE: ORS WILL REIMBURSE UP TO $150 PER QUARTER**

Date Approved_____ Approved by _____ Date to Financial Svs. _____

Return this form to: Attention: Tiffeni Wall Office of Recovery Services, P.O. Box 45033, SLC, UT 84145
Phone (801)536-8902 Fax: (801) 536-8509 E-mail: orsfidm@utah.gov